Alabama Medicaid Pharmacy
Child Growth Failure[1] PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

PRESCRIBER INFORMATION

Prescriber name _____ NPI # _____ License # _____

Address _____ Phone # with area code _____

City/State/Zip _____ Fax # with area code _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing Practitioner Signature Date

PHARMACY INFORMATION

Dispensing pharmacy _____ NPI # _____

NDC # _____ J Code _____ (if applicable) Qty. requested per month _____

Phone # with area code _____ Fax # with area code _____

DRUG/CLINICAL INFORMATION

❑ Initial request ❑ Renewal Drug requested _____ Proposed duration of therapy _____

Strength/Quantity _____ Daily dose _____ Height _____ Weight _____

Patient must have one of the following primary diagnoses listed below, confirmed by a board certified endocrinologist or a board certified pediatric nephrologist for Chronic Renal Insufficiency:

❑ Documented Growth Hormone Deficiency ❑ Turner Syndrome ❑ Severe Primary IGF-1 Deficiency
❑ Growth Deficience due to Chronic Renal Insufficiency ❑ Growth Hormone Gene Deletion ❑ Prader-Willi Syndrome

Information Required for all Diagnoses:

1. Growth velocity or height value in standard deviations below the mean _____
2. Is patient's height less than 5th percentile? ❑ Yes ❑ No
3. Has the patient been screened for intracranial malignancy or tumor? ❑ Yes ❑ No (If no, request will be denied)
4. If a history of malignancy exists, has patient been free of recurrence for at least the past 6 months?
   ❑ Yes ❑ No (If no, request will be denied) ❑ No malignancy
5. Does the patient have any of the following contraindications? Check all that apply.
   ❑ Pregnancy ❑ Proliferative or preproliferative diabetic retinopathy ❑ Pseudotumor cerebri or benign intracranial HTN
   ❑ Closed epiphyses (After epiphyseal closure use Adult Growth Hormone Therapy criteria.)
6. Is patient's thyroid function normal? ❑ Yes ❑ No

Diagnosis Specific Information Required:

1. **Growth Hormone Deficiency:** Confirmed with provocative testing and IGF-1 levels. IGF-1 Level _____ Date _____
   Provocative Testing: Test 1: Type _____ Result _____ Date _____
   Test 2: Type _____ Result _____ Date _____
2. **Turner Syndrome:** Karyotyping Date _____ Results _____
3. **Chronic Renal Insufficiency:** Is the patient currently receiving dialysis? ❑ Yes ❑ No GFR _____ Date _____
4. **Severe Primary IGF-1 Deficiency:** IGF-1 level in standard deviations below the mean _____
   Does the patient have elevated growth hormone? ❑ Yes ❑ No If yes, indicate growth hormone level _____

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____ _____
Reviewer's Signature Response Date/Hour